

Primary Care Rate Increase:

Background:

Section 1202 of the Affordable Care Act amends sections 1902(a)(13), 1902(jj), 1905(dd) and 1932(f) of the Social Security Act to require payment of the Medicare rate for certain primary care services provided in calendar years 2013 and 2014. This provision applies to evaluation and management (E&M) and vaccine administration services when delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. States will be eligible to receive 100 percent Federal Medical Assistance Percentage (FMAP) for increased expenditures equal to the difference between the Medicare rate and the State Plan rate as of July 1, 2009 for these same services, for both fee-for-service claims and managed care claims.

In addition, the CMS final rule *Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration under the Vaccines for Children Program* updates the interim regional maximum fees that providers may charge for vaccine administration under the Vaccines for Children (VFC) program.

Questions & Answers:

[This FAQ document has been updated as of August 5, 2013. The changes are in red ink.](#)

The Health Care Authority (HCA) will continue to provide clarifying information as it is received from the Centers for Medicare and Medicaid Services (CMS). Please note that this document will be updated frequently to reflect new information. Providers are advised to check the following link frequently for new information: http://www.hca.wa.gov/medicaid/Pages/aca_rates.aspx

Unless stated otherwise, the requirements and guidance provided here apply to both fee-for-service and managed care providers contracted with HCA to perform services for Medicaid clients. Again, please note that more guidance from CMS is forthcoming and will be posted at the following link as it becomes available: http://www.hca.wa.gov/medicaid/Pages/aca_rates.aspx

Additionally, the information provided in this document may change based on new federal guidance received in the coming weeks.

Please check http://www.hca.wa.gov/medicaid/Pages/aca_rates.aspx frequently in lieu of calling or emailing HCA staff.

To view the final rule from CMS with full provision requirements, please visit: <https://www.federalregister.gov/articles/2012/11/06/2012-26507/rin-0938-aq63>

NOTE: Please note that this document will be updated as information is received from CMS. This document is current as of 8/5/2013.

Please also refer to the FAQ documents posted by CMS on <http://www.medicaid.gov/AffordableCareAct/Provisions/Provider-Payments.html>

Which providers are eligible to receive enhanced payments?

Per CMS, eligible providers are physicians with a specialty designation of **family medicine, general internal medicine, or pediatric medicine**. Specialists and subspecialists within those designations as recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), or the American Board of Physician Specialties (ABPS) also qualify for the enhanced payments.

In addition, to be eligible for enhanced payments, physicians must satisfy the following requirements:

- a. Physicians must first self-attest to a covered specialty or subspecialty designation.
- b. As part of that attestation, physicians must specify that they either are board-certified in an eligible specialty or subspecialty and/or that 60 percent of their paid Medicaid claims for the most recently completed calendar year were for the eligible E&M and vaccine administration services.

Physicians will be allowed to self-attest that they are eligible to receive the enhanced payments. In order to receive the enhanced payments, each eligible physician is required to fill out, sign, and submit the attestation form to HCA.

How do I submit the attestation form?

The attestation form can be found at the following link:

http://www.hca.wa.gov/medicaid/Pages/aca_rates.aspx Forms can be submitted by fax at **(360) 586-7498** or email to prvrates@hca.wa.gov. Please note that if submitting via email, the completed form must be scanned.

Is there anything we (providers) can do to facilitate the processing of attestation forms?

Yes. If you plan to submit a large number of attestation forms from the same group/clinic, you could help us by filling out an excel spreadsheet with your physicians' information. The excel file named "Provider Information" is posted to this website. Populate it with your physicians' information (name, address, NPI, etc.) and email to prvrates@hca.wa.gov

This file will **not replace** the individual attestation forms. Its purpose is to expedite the HCA's processing of the attestation forms.

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If a physician practices medicine in one of the designated specialties/subspecialties, but does not have a board certification in these specialties/subspecialties, or is board certified in another specialty, can he/she qualify for enhanced payment?

If a physician practices medicine in one of the designated specialties/subspecialties, but does not have a Board certification in these specialties/subspecialties (or he/she is Board certified in another specialty, e.g. surgery or dermatology), he/she must meet the 60% requirement to qualify for enhanced payment.

If a physician practices medicine in another specialty (e.g. surgery or dermatology) and is board certified in that specialty and meets the 60 percent requirement, can he/she qualify for the enhanced payment?

Only physicians with a specialty designation of family medicine, general internal medicine, or pediatric medicine, or any subspecialty within these specialties are eligible to receive enhanced payments. If a physician is board-certified in another specialty (e.g., surgery), but meets the 60 percent requirement, then he/she is not eligible for enhanced payments if not practicing medicine in one of the required specialties/subspecialties.

Please refer to the CMS FAQ document at the following link for additional guidance:
<http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/CMCS-Ask-Questions.html>

What process will be in place for newly enrolled physicians who are not board-certified and who do not have sufficient claims history with Washington State Medicaid?

A new provider with a specialty designation of family medicine, general internal medicine, or pediatric medicine must meet the 60-percent requirement during at least one full month of paid claims history with Medicaid.

Will managed care providers be able to use the same self-attestation form as fee-for-service providers?

The self-attestation form is for all providers. If a physician is both a fee-for-service and a managed care provider, then he/she will submit one form to HCA. All attestation forms must come to HCA directly, regardless of whether or not the provider currently is contracted with HCA.

Will there be a charge to physicians for the self-attestation form?

There is no charge for the form.

Is there a deadline for submitting the attestation form?

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We have not established a deadline for submitting the attestation forms yet. However, we may do so in the near future. If we determine that a deadline is necessary, we will give providers sufficient notice and update the FAQ with additional information.

Update: In order to assure timely payment and re-processing of claims, HCA urges providers to submit their attestation forms by **Friday, May 31st**. This timeframe will allow HCA staff to process the forms in time for the system change slated for mid-July 2013. Forms can be faxed to (360) 586-7498 or emailed to prvrates@hca.wa.gov. To avoid unnecessary delays in the processing of the forms, HCA urges providers to fill out the attestation forms completely (including attaching required information) and legibly. We cannot process the forms if information is missing. Please visit our website for specific requirements and updates: http://www.hca.wa.gov/medicaid/Pages/aca_rates.aspx

We have been asking our larger clinics/provider groups to submit an Excel spreadsheet with provider information in addition to the attestation forms. This will help to expedite the processing of the forms. You can find the blank Excel file "Provider Information" on our website.

Update: Despite the May 31st deadline, many providers have been sending in their attestation forms late. In order to accommodate these providers, HCA has extended the deadline through August 31st.

IMPORTANT:

Providers eligible for the rate increase whose attestation form is received by HCA before or on August 31st will receive payments at higher rates for qualifying services rendered on or after January 1, 2013.

Providers eligible for the rate increase whose attestation form is received by the HCA after August 31st will receive higher rates for qualifying services rendered on or after the date the form is received at HCA.

Can new providers who enroll with Medicaid after May 31st submit their attestation form after the deadline?

Yes. Newly enrolled providers, who will join HCA after May 31st and who are eligible for the rate increase, will be allowed to submit their attestation forms upon enrollment with HCA.

How will physicians calculate the 60 percent of required claims history with Washington Medicaid?

Please refer to the list of eligible E&M codes and vaccine administration codes available at http://www.hca.wa.gov/medicaid/Pages/aca_rates.aspx. To calculate your percentage, divide the total volume of E&M codes and vaccine administration codes paid by Medicaid by the total volume of all codes paid by Medicaid. This calculation must be done for each eligible provider individually and **not** as a group practice.

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How will HCA verify that providers are eligible for the increase?

HCA will be reviewing a statistically valid sample of physicians' claims data in 2013 and 2014 for the purpose of verifying provider eligibility for the enhanced payments. Reimbursement for claims paid at enhanced rates to providers who are ineligible will be recouped.

What other exclusions apply?

Per CMS, services reimbursed through a federally qualified health center (FQHC) or rural health clinic (RHC) are not eligible for enhanced payments.

Services performed for clients in standalone non-Medicaid programs, [e.g. Children's Health Insurance Program (CHIP)] are not eligible for enhanced payments.

I am an eligible physician and perform eligible services for two clinics, one of them is an FQHC/RHC clinic and the other one is a non-FQHC/RHC clinic. Should I fill out and submit the attestation form?

Yes. The vast majority of services billed by an FQHC/RHC will not receive the enhanced payment (see below for additional information), while many of the same services billed by a non-FQHC/RHC clinic will receive the enhanced payment. Per CMS, FQHCs and RHCs are excluded from receiving the enhanced rates because these clinics are reimbursed on the basis of an all-inclusive rate.

According to the Rural Health Clinic (RHC) Medicaid Provider Guide (MPG), some services provided by Rural Health Clinics, such as immunizations, are billed as non-encounter services. RHCs receive the same reimbursement for those services as a non-RHC clinic. Would those services qualify for the enhanced rates?

While administration fees for drugs and vaccines given in the provider's office are not paid separately when performed on the same day as an encounter, an injection-only service with no corresponding office visit or other encounter-eligible service may be billed FFS by an RHC. When a corresponding office visit or other encounter-eligible service is not provided on the same day as the injection, both the drug (if not provided to the clinic free of charge) and the injection may be billed FFS using the corresponding CPT and/or HCPCS procedure code(s). The clinic's NPI and their non-RHC taxonomy as well as the servicing provider's taxonomy must be included on the bill.

In the above scenario, the RHC could receive the enhanced payment, if the following conditions are true:

1. The service is provided by an eligible physician (or under the personal supervision of an eligible physician) who has a self-attestation form on file with HCA. Please refer to the provider eligibility criteria described in this and other documents posted on this website.

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2. The services provided are not already reimbursed through the all-inclusive rate.
3. The services are billed FFS using the corresponding CPT and/or HCPCS procedure code(s).
4. The modifier **AG** is attached to each eligible code.
5. The clinic's NPI and their non-RHC taxonomy as well as the servicing provider's taxonomy are included on the bill.

Will HCA continue to reimburse providers at the lower of the billed charges or the published rate under this rule?

Yes. Medicaid always pays the provider the lower of the submitted charges or the published rate. This principle will not change under the primary care rate increase rule. This means that if your submitted charges are lower than the enhanced rate, the system will pay the amount equal to your submitted charges. In the federal Q&A sets I & II, CMS emphasizes that this principle will stay in place: <http://medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/CMCS-Ask-Questions.html>

Will non-physician practitioners be eligible for the enhanced payments?

Non-physician practitioners, such as ARNPs and PA-Cs, performing E&M services and vaccine administration services, are eligible for the enhanced payments as long as they perform these services under the personal supervision of an eligible physician. Per CMS, the physician must accept professional responsibility and legal liability for the services provided by an ARNP or PA-C.

The eligibility of services provided by non-physician practitioners is dependent on:

- 1) The eligibility of the physician and
- 2) Whether or not the physician accepts professional responsibility for the services provided by the advanced non-physician practitioner. As previously noted, the physician is eligible only if he/she self-attests to a specified specialty designation and also to either being appropriately Board certified or meeting the 60% threshold.

The supervising physician must have the self-attestation form on file with HCA.

Does "personal supervision" mean the physician must be physically present while the service is being performed?

Upon our request for clarification, CMS responded that being physically present was not required per federal rule. However, they repeated that the physician must accept professional responsibility/liability for the services provided by individuals he or she supervises.

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Can ARNPs/PA-Cs fill out the attestation form?

No. The attestation form is to be filled out by eligible physicians only.

What is the attestation process for qualifying advanced non-physician practitioners?

We have added a second page to the attestation form for eligible supervising physicians to list advanced non-physician practitioners they supervise and to attest that the physician is professionally/legally responsible for services performed by these individuals. The supervising physician will fill out and submit both pages of the attestation form.

If the eligible physician does not supervise any non-physician practitioners, he or she will only fill out and submit page 1 of the form.

I am an eligible physician who supervises an ARNP or PA. I have already submitted my attestation form. Do I need to fill out the form again and submit both pages?

No. If you already submitted the form, you will only fill out and submit page 2 of the form.

What services are eligible for the enhanced payments?

Please see the attachment at http://www.hca.wa.gov/medicaid/Pages/aca_rates.aspx for a list of eligible codes. Please note that non-covered services by Washington Medicaid are not eligible for the enhanced payments.

Update: HCA has added the enhanced payment information to the list of eligible codes. This payment information applies to calendar year 2013 and is subject to CMS approving our SPA.

Do providers have to bill differently for these services?

Yes. Eligible providers (including Managed Care providers) must attach modifier **AG** to each code in order to receive enhanced payment. This will allow HCA to identify claims in ProviderOne that may be eligible for enhanced payments. HCA will use the information received via the attestation form (e.g., national provider identifier) to ensure that only eligible providers receive the enhanced payment.

Therefore, it is very important that providers correctly fill out and submit the self-attestation form as soon as possible.

We received many questions from providers regarding the modifier. Some providers did not find out about the modifier requirement until recently and have not been billing it. To accommodate our

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providers, we are clarifying that claims submitted without the modifier should not be rebilled for that purpose. The modifier is a very important piece of the implementation process, therefore we strongly urge providers to bill the modifier as soon as they determine that they are eligible for the rate increase.

If I am billing another modifier with the code, should modifier AG be placed in the primary modifier position?

No. If you are attaching another modifier (e.g. SL or 25), modifier AG should be placed in the secondary position.

When will providers see the enhanced payments?

For a limited period of time after January 1, 2013, claims will be paid at regular Medicaid rates. CMS will not allow enhanced payments to be made until the State Plan Amendment (SPA) is approved and attestation forms are received and processed by HCA. Eligible services with dates of services starting January 1, 2013 will be retroactively adjusted for enhanced payments.

Update:

Payment information for fee-for-service claims: The first batch of eligible provider NPIs was submitted to the system in July 2013. As a result, many of you have noticed an increase in reimbursement for current claims. The remaining list of NPIs will be submitted to the system in mid-August and early September.

Mass adjustment of fee-for-service claims: Claims paid since January 1, 2013 will be retroactively adjusted by the system at the claim level (no lump sum payments) for eligible providers who submitted their attestation form by August 31st. Mass adjustment of claims will take place in September and will be done incrementally to manage a very large volume of claims.

I noticed that my claims have been paying at higher rates since July. Can I reprocess my own claims for higher payment rather than wait until September?

Yes. If you've noticed an increase in payment, it means your NPI was "flagged" in the system with a special indicator, which enables you to receive higher payment. With this indicator in place, you may reprocess your own claims for higher payment rather than wait for automatic reprocessing that will begin in September.

For managed care physicians, the description of payment methodology will be posted at http://www.hca.wa.gov/medicaid/Pages/aca_rates.aspx once it is submitted and approved by CMS during the first quarter of 2013.

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Update: CMS approved HCA's Managed Care Methodology. Per the approved methodology, the enhanced portion of payments will be made based on the encounter data submitted by the plans. The Health Care Authority will complete the quarterly analysis and will submit the enhanced payment to the plans. Payments to eligible providers will be made by the managed care plans.

What SPA- related activities have been done by HCA thus far?

HCA has published the Tribal Letter Notification and the Public Notice Letter, which are steps necessary prior to HCA submitting the SPA to CMS. HCA anticipates that the SPA will be submitted to CMS in early January 2013; however, there is no date available currently as to when CMS will approve the SPA.

Update: we have submitted our SPA and supplemental documents to CMS for an informal review.

Update: We submitted the SPA documents and proposed Managed Care Methodology to CMS for formal review and approval. Copies of submitted documents have been posted to our website. Please note that these documents may change as we receive CMS's feedback. We will publish an update upon CMS's approval of these documents.

Update: The final SPA and Managed Care Methodology with the approval letters from CMS are posted to the website.

How will HCA calculate the enhanced payments?

If approved by CMS, HCA plans to "blend" the Medicare values for the two WA localities ('King County' and the 'Rest of WA') established by CMS. This blending allows for a single statewide rate for each eligible service. Please see WAC 182-531-1850 for further information on payment methodology for physician-related services.

Update: HCA opted out using the rates calculated by CMS for Washington State. We have posted a list of eligible CPT codes and the most recently released enhanced rates specific to Washington State – please see the "Eligible Codes & Enhanced Rates" file on our website. **Reason for update:** CMS detected an error in their earlier rates calculations and provided HCA with an updated rates file for CY 2013.

Does HCA plan to change Medicare rates as updates become available?

No. In order to reduce administrative burden, HCA will "lock" Medicare rates at the beginning of 2013 and, again, at the beginning of 2014. These rates will not be updated at the beginning of the state fiscal year (July) as they have been historically.

Do the requirements of this rule apply to Managed Care Organizations?

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Yes. The same eligibility requirements for providers and services apply to managed care providers. More information on how HCA will implement this requirement for managed care providers is forthcoming.

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